OMB Control No. 2900-0104
Respondent Burden: 30 Mins.

Department of Veterans Affairs

1. FILE NUMBER
C-

REPORT OF ACCIDENTAL INJURY IN SUPPORT OF CLAIM FOR COMPENSATION OR PENSION

2. FIRST, MIDDLE, LAST NAME OF VETERAN AND ADDRESS

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INSTRUCTIONS

Read carefully and answer questions fully. If answer is "No" or "None," so state. Please type or print, or write plainly.

After completion, return this form to the Department of Veterans Affairs office processing your claim.

Call VA at 1-800-827-1000 for help in filling out this form or with any questions.

SECTION I - CIRCUMSTANCES OF ACCIDENT

3A. DATE AND TIME OF ACCIDENTAL INJURY

3B. PLACE OF ACCIDENT (Identify location, such as house number, street, intersections, name or number of public highway, name of nearest city, if applicable, name and location of military post, foreign city and country, (if applicable)

4A. DID THE ACCIDENT OCCUR WHILE YOU WERE IN THE ARMED FORCES?
☐ YES ☐ NO (If "Yes," complete Items 4B and 4C)

4B. MILITARY ORGANIZATION OF WHICH YOU WERE A MEMBER

4C. AT TIME OF THE ACCIDENT, WERE YOU ON MILITARY DUTY, AUTHORIZED PASS OR LEAVE, ABSENT WITHOUT LEAVE, ETC.? (Explain fully)

5A. WERE ALCOHOLIC INTOXICANTS, NARCOTICS, DRUGS OR MISCONDUCT OF ANY KIND ON THE PART OF PERSONS CONCERNED INVOLVED IN THIS ACCIDENT?
☐ YES ☐ NO (If "Yes," complete Item 5B)

5B. EXPLAIN FULLY ANSWER TO QUESTION IN ITEM 5A

6A. DID CIVILIAN OR MILITARY POLICE MAKE REPORT OF THE ACCIDENT?
☐ YES ☐ NO (If "Yes," complete Item 6B)

6B. FULL NAME AND COMPLETE MAILING ADDRESS OF CIVILIAN POLICE AND/OR MILITARY POLICE WHERE SUCH REPORT MAY BE FILED

7. FULL NAME AND MAILING ADDRESS OF THE PERSON IN WHOSE NAME THE REPORT WAS FILED

8. FULL DESCRIPTION OF HOW THE ACCIDENT OCCURRED, INCLUDING INJURIES YOU RECEIVED (If this was a traffic accident, complete also Items 9 through 24, Section II. Complete Section III for any type of accident)

SECTION II - REPORT OF TRAFFIC ACCIDENT

INSTRUCTIONS: Identify one vehicle as the "first vehicle". If another vehicle was involved in the accident, identify it as the "second vehicle". If you were riding in a vehicle involved in the accident, identify it as the "first vehicle".

9. TYPE OF FIRST VEHICLE	10. TYPE OF SECOND VEHICLE (If any)	11A. WERE YOU? ☐ DRIVER ☐ PASSENGER	11B. IN WHICH VEHICLE WERE YOU?

12. IF PASSENGER, GIVE SEAT POSITION	13. IF PEDESTRIAN, WHAT WAS YOUR POSITION IN RELATION TO VEHICLE(S)?
14. DIRECTION OF TRAVEL OF FIRST VEHICLE	15. DIRECTION OF TRAVEL OF SECOND VEHICLE (If any)
16. APPROXIMATE SPEED OF FIRST VEHICLE	17. APPROXIMATE SPEED OF SECOND VEHICLE (If any)
18. WHAT WERE YOU DOING PRIOR TO AND AT TIME OF ACCIDENT?	
19. TYPE OF ROADWAY (Concrete, asphalt, etc.)	20. CONDITION OF ROADWAY (Wet, dry, icy, etc.)
21. TRAFFIC CONTROLS (Traffic lights, road signs, obstruction, etc.)	
22. WEATHER CONDITIONS (Clear, rain, snow, fog, etc.)	23. LIGHT (Dawn, daylight, dusk, darkness with artificial light, darkness with no light)
24. OTHER PERTINENT DETAILS	

SECTION III - ALL ACCIDENTS (To be completed for any type of accident)

25. WITNESSES TO ACCIDENT (Type or print)

FULL NAME OF WITNESS	MAILING ADDRESS Number and street, city, State and ZIP Code)

26. HISTORY OF TREATMENTS (Type or print)

TREAT-MENT	FULL NAME OF DOCTOR OR HOSPITAL FURNISHING TREATMENT	MAILING ADDRESS (Number and street, city, State and ZIP Code)	DATE TREATED
FIRST AID			
SECOND			
THIRD			

CERTIFICATION: I hereby certify that the entries made herein are true and correct to the best of my knowledge and belief.

27. SIGNATURE OF VETERAN OR FIDUCIARY	28. DATE

WITNESSES TO SIGNATURE OF VETERAN IF MADE BY "X" MARK

NOTE: Signature made by mark must be witnessed by two persons to whom the veteran is personally known and the signatures and addresses of the witnesses must be entered below.

29A. SIGNATURE OF WITNESS	29B. ADDRESS OF WITNESS (Number and street, city, State and ZIP Code)
30A. SIGNATURE OF WITNESS	30B. ADDRESS OF WITNESS (Number and street, city, State and ZIP Code)

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

PRIVACY ACT INFORMATION: No allowance of compensation or pension may be granted unless this form is completed fully as required by existing law (38 U.S.C. chapters 11 and 15). The responses you submit are considered confidential (38 U.S.C. 5701). The information requested by this form is considered relevant and necessary to determine maximum benefits under the law. The information submitted may be disclosed outside VA only if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register.

RESPONDENT BURDEN: VA may not conduct or sponsor, and respondent is not required to respond to this collection of information unless it displays a valid OMB Control Number. Public reporting burden for this collection of information is estimated to average 30 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have comments regarding this burden estimate or any other aspect of this collection of information, call 1-800-827-1000 for mailing information on where to send your comments.